



Developmental History and Background Information

Child's Name: _____ Date of birth: _____

Age child began: Sitting: _____ Crawling: _____ Walking: _____ Talking: _____

Any speech difficulties: _____ If yes, please explain: _____

Language(s) spoken at home: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

Occupation: _____ Occupation: _____

Work phone number: _____ Work phone number: _____

Cell phone number: _____ Cell phone number: _____

Does either parent experience work-related travel on a regular basis? If so, please explain: _____

Does the child have any siblings: _____ If yes, please list names/ages

Child's Health History:

Did the child experience any complications at birth? _____

Has the child experienced any serious illnesses and/or hospitalization? _____ If yes, please explain.

Does the child have any disabilities or special physical conditions? If yes, please explain.

Does the child have any known allergies to medication, specific foods, insect bites/stings, environmental allergens, etc.... If yes, please explain.

Has the child been prescribed an EPI pen if he/she has known allergies?

Is the child currently taking medication on a regular basis?

Please describe your child's eating habits:

What time does your child typically go to bed? _____

What time does your child typically wake up? _____

Is your child potty trained? _____

If so, at what age did your child begin to use the toilet without assistance? _____

If your child is not potty trained, what procedures or routine are you using at home to help your child become more independent? _____

What is your child's favorite activity?

What is your child's least favorite activity?

Parent/guardian signature: _____

Date: _____